

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Antelope Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44567 North 15th St. West Lancaster, CA 93534	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, the facility failed to report the allegation of an employee-to-resident physical abuse (any intentional act causing injury or trauma to another person through bodily contact) to the State Survey Agency (SSA) for one of four sampled residents (Resident 2). On 6/9/2026, an allegation that Certified Nursing Assistant (CNA) 4 pushed and punched Resident 2 on the face was reported to Licensed Vocational Nurse (LVN) 3, LVN 4, and the Director of Nursing (DON). The SSA did not receive the report from the Abuse Coordinator for the allegation of abuse. This deficient practice had the potential to result in unidentified abuse and failure to protect other residents from abuse. Findings: During a review of Resident 2's undated admission Record, the admission Record indicated the facility admitted the resident on 2/25/2026 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), age-related osteoporosis (a condition where bones become brittle, weak, and highly porous as a person gets older), and muscle weakness. During a review of Resident 2's History of Present Illness and Physical Exam (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 2/26/2026, the H&P indicated Resident 2 had the capacity to make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 5/21/2026, the MDS indicated Resident 2's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact. The MDS indicated Resident 2 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on rolling to the left side and right side, sit to lying position (the ability to move from sitting on side of bed to lying flat on the bed), and lying to sitting position (the ability to move from lying on the back to sitting on the side of the bed and with no back support). The MDS indicated Resident 2 was dependent on facility staff on self-care including eating, oral (mouth) hygiene, toileting hygiene, shower, dressing up, and personal hygiene. During an interview on 6/30/2026 at 2:20 p.m. with LVN 3, LVN 3 stated that on 6/9/2026, LVN 4 reported CNA 4 allegedly went on top of Resident 2 and rough handled the resident. LVN 3 stated LVN 4 informed her that the alleged abuse was reported already (LVN 3 could not remember to whom the alleged abuse was reported to). LVN 3 stated she did not follow up on Resident 2's reported allegation of abuse against CNA 4. During a telephone interview on 7/1/2026 at 10:16 a.m. with LVN 4, LVN 4 stated on 6/9/2026 between 1 a.m. to 2 a.m., Resident 2 reported that CNA 4 punched her (Resident 2) on the face. LVN 4 stated she reported the alleged abuse to Registered Nurse (RN) 2 and sent a text message to the DON. LVN 4 stated she did not get a response from the DON. LVN 4 stated she did not report Resident 2's allegation of abuse to the SSA. During a concurrent interview and record review on 7/1/2026 at 1:17 p.m. with RN 1, Resident 2's medical records were reviewed. RN 1 stated there was no documented evidence of Resident 2's assessment and monitoring on 6/9/2026 to 6/30/2026 related to Resident 2's allegation of abuse. RN 1 stated she did not receive a report regarding Resident 2's allegation of abuse against CNA 4. During an interview on 7/1/2026 at 3:14 p.m. with DON, the DON stated Resident 2's allegation against CNA 4 was not reported to the SSA. The DON stated not reporting Resident 2's allegations of abuse could negatively (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555456
		If continuation sheet Page 1 of 9

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	affect the resident's psychosocial wellbeing (a dynamic relationship between a person's psychological state [thoughts, feelings, and mental health] and their social environment) and cause the resident emotional distress. The DON further stated allegations of abuse that were not reported could cause the abuse to continue. The DON acknowledged and stated the facility failed to report Resident 2's allegation of abuse against CNA 4 within two hours. During a concurrent interview and record review on 7/1/2026 at 3:40 p.m. with the Administrator (ADM), the facility's policy and procedure (PnP) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 5/20/2026, was reviewed. The PnP indicated if resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The PnP defined immediately as within two hours of an allegation involving abuse. The ADM stated he was the facility's Abuse Coordinator. The ADM acknowledged and stated the facility failed to report the allegation of abuse within two hours.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to follow professional standards of nursing practice for two of four sampled residents (Resident 1 and Resident 2) by failing to: Ensure Certified Nursing Assistant (CNA) 2 reported Resident 1's unwitnessed fall on 6/4/2026 to the licensed nurses. Ensure CNA 2 did not move Resident 1 until the licensed nurses had assessed the resident following Resident 1's unwitnessed fall. Ensure licensed nurses appropriately assessed and monitored Resident 1's medical status following the resident's Change of Condition (COC - when there is a sudden change in a resident's condition) on 6/4/2026 related to the resident's fall. Ensure licensed nurses appropriately assessed and monitored Resident 2's medical status following the resident's Change of Condition (COC) on 6/9/2026 related to the alleged physical abuse against CNA 4. These deficient practices had the potential to result in the failure to identify continued or worsening clinical deterioration thereby placing Resident 1 and Resident 2 at risk for adverse health outcomes and compromised safety. Findings: a. During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted Resident 1 on 9/24/2024 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), chronic obstructive pulmonary disease (COPD - a progressive, long-term lung condition that damages the airways and air sacs, making it hard to breathe), and spondylopathy (any disease or disorder of the spine). During a review of Resident 1's Physician Order, dated 12/25/2024, the Physician Order indicated apixaban (also known as Eliquis - a prescription anticoagulant medication, taken by mouth, that acts as a blood thinner) 2.5 milligrams (mg - unit of measurement), every 12 hours for atrial fibrillation (a type of irregular heartbeat). During a review of Resident 1's Care Plan Report on Falls, last revised on 1/15/2026, the Care Plan Report indicated Resident 1 was a high risk for falls with or without injury related to antihypertensive medications (a prescribed medication that lowers a person's blood pressure [the force of person's blood pushing against the walls of arteries as heart pumps it throughout the body]), diuretic medication (used to help the body eliminate excess salt and water through urine), hypoglycemia (low blood sugar), and unsteady gait. Resident 1's Care Plan Interventions indicated to anticipate and meet the resident's needs, monitor for changes in condition affecting risk for falls, notify Resident 1's physician, and monitor the resident for delayed injury for 72 hours. During a review of Resident 1's Fall Risk Observation and Assessment, dated 3/30/2026, the Fall Risk Observation and Assessment indicated Resident 1 had a total score of 12. A fall risk score of nine to 15 indicated Resident 1 was a moderate risk for falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/30/2026, the MDS indicated Resident 1's cognitive (refers to the mental processes involved in gaining knowledge, understanding, and thinking) skills for daily decision making was intact. The MDS indicated that Resident 1 required partial and moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for shower and bathing. The MDS indicated that Resident 1 required setup assistance (resident completes activity while the helper assists prior to or following the activity) with eating, toileting, and oral hygiene. During a review of Resident 1's Change in Condition (COC - when there is a sudden change in a resident's condition) Evaluation, dated 6/6/2026, the COC Evaluation indicated the resident had a fall that resulted to a blue discoloration with diffused yellow edges on the right iliac crest (the curved top ridge of the hip bone) and right buttocks. During an interview on 6/30/2026 at 11:59 a.m. with Resident 1, Resident 1 stated on 6/4/2026, CNA 2 brought him into the shower room for his regular shower. Resident 1 stated CNA 2 placed him inside the shower cubicle, turned on the shower, and then stepped out closing the shower curtain behind her. Resident 1 stated he stood up to scrub his body and when he sat back down, he slipped and the shower chair rolled back. Resident 1 stated he informed CNA 2 that he hit his back on the shower chair's armrest and landed on his buttocks. Resident 1 stated CNA 2 pulled him up by the arm and sat him down on the shower chair. Resident 1 stated there were no licensed nurses who came to assess him after the fall. Resident 1 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that he did not request to take the shower by himself, CNA 2 just wheeled him in the shower and stepped out of the shower area. During an interview on 7/1/2026 at 11:25 a.m. with CNA 2, CNA 2 stated Resident 1 had a shower on 6/4/2026. CNA 2 stated she assisted Resident 1 into the shower room. CNA 2 stepped out and closed the shower curtain but stated Resident 1's feet were visible under the shower curtain. CNA 2 stated Resident 1 was observed sitting on the floor with the shower chair behind the resident. CNA 2 stated she used her right arm, grabbed Resident 1's right arm, and pulled the resident up using a gait belt (an assistive device used to help safely transfer or assist a person). CNA 2 stated she assisted Resident 1 back up to the shower chair, assisted him (Resident 1) in dressing up, and then transferred the resident to the wheelchair. CNA 2 stated she did not call for assistance before moving Resident 1, following the resident's fall inside the shower room. CNA 2 stated she did not notify the licensed nurses about Resident 1's fall. CNA 2 acknowledged and stated Resident 1 should be visible during shower to assist and anticipate the resident needs. During an interview on 6/30/2026 at 12:33 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated there were no reported resident falls on 6/4/2026 at the station she was working at. LVN 2 stated she was not aware of Resident 1's fall in the shower room on 6/4/2026. During a concurrent interview and record review on 7/1/2026 at 1:17 p.m. with Registered Nurse (RN) 1, Resident 1's Progress Notes, dated 6/4/2026 to 6/9/2026, were reviewed. RN 1 stated CNA 2 should have reported Resident 1's unwitnessed fall to the licensed nurses to ensure Resident 1 was assessed and monitored. RN 1 stated Resident 1 should be monitored every shift for 72 hours after a change of condition. RN 1 stated Resident 1's Progress Notes indicated there was no documented evidence that the resident was assessed and monitored on the following shifts: 6/4/2026 (7 a.m. to 3 p.m. shift, 3 p.m. to 11 p.m. shift, and 11 p.m. to 7 a.m. shift), 6/5/2026 (7 a.m. to 3 p.m. shift, 3 p.m. to 11 p.m. shift, and 11 p.m. to 7 a.m. shift), 6/6/2026 (3 p.m. to 11 p.m. shift), 6/7/2026 (11 p.m. to 7 a.m. shift). RN 1 stated care not documented was considered not provided. RN 1 stated that failure to document Resident 1's medical status monitoring following a change of condition could put Resident 1's safety at risk. During a concurrent interview and record review on 7/1/2026 at 3:14 p.m. with the Director of Nursing (DON), Resident 1's 72-hour Neuro (a prefix that relates to the nervous system [brain, spinal cord, and all the nerves], which is the body's command center) Check List, dated 6/6/2026 to 6/8/2026, were reviewed. The DON stated Resident 1's 72-hour Neuro Check List indicated there was no documented evidence that the resident was assessed and monitored on 6/6/2026 at 3:20 p.m. The DON stated Resident 1 was a fall risk resident. The DON stated Resident 1's fall should be reported to the licensed nurses to ensure the resident was assessed and monitored following an unwitnessed fall. The DON stated moving Resident 1 from the ground to the chair before a licensed nurse had assessed the resident following an unwitnessed fall could cause more injury to the resident. The DON further stated Resident 1 was on an anticoagulant medication that could cause undetected internal bleeding following an unwitnessed fall. The DON acknowledged and stated the facility failed to follow the facility's policy and procedure on fall management that included reporting falls to the licensed nurses. The DON further stated the facility failed to assess, monitor, and document Resident 1's medical status following an unwitnessed fall. During a review of the facility's policy and procedure (PnP) titled, Fall Prevention and Management Program, last reviewed on 5/20/2026, the PnP indicated the purpose .to develop, implement, monitor, and evaluate residents using an interdisciplinary approach. The program will use strategies that foster resident independence and increase quality of life while promoting safety for residents and staff. The program focuses on reducing incidence of resident falls and mitigating risk of falls through a resident focused team approach. The PnP indicated a fall is any occasion in which a person verbalizes he or she has had a fall or when a person is found on the floor. The PnP indicated following a residents fall, the licensed nurse will notify the RN supervisor and assess the resident for injuries and necessary treatment.if there is no apparent injury, assist resident off the floor. The PnP indicated .document resident condition after fall for 72 hours in nursing progress notes. Licensed nurse will document ongoing assessments to include neuro checks for (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unwitnessed falls.and response to care and treatment each shift. During a review of the facility's PnP titled, Charting and Documentation, last reviewed on 5/20/2026, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The PnP indicated documentation in the medical record will be objective, complete and accurate. During a review of the facility's PnP titled, Change in a Resident's Condition or Status, last reviewed on 5/20/2026, the PnP indicated the nurse will notify the resident's attending physician or physician on call when there has been a (an).accident or incident involving the resident. need to alter the resident's medical treatment significantly. The PnP indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical or mental condition or status. b. During a review of Resident 2's undated admission Record, the admission Record indicated the facility admitted the resident on 2/25/2026 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), age-related osteoporosis (a condition where bones become brittle, weak, and highly porous as a person gets older), and muscle weakness. During a review of Resident 2's History of Present Illness and Physical Exam (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 2/26/2026, the H&P indicated Resident 2 had the capacity to make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 5/21/2026, the MDS indicated Resident 2's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact. The MDS indicated Resident 2 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on rolling to the left side and right side, sit to lying position (the ability to move from sitting on side of bed to lying flat on the bed), and lying to sitting position (the ability to move from lying on the back to sitting on the side of the bed and with no back support). The MDS indicated Resident 2 was dependent on facility staff on self-care including eating, oral (mouth) hygiene, toileting hygiene, shower, dressing up, and personal hygiene. During an interview on 6/30/2026 at 2:20 p.m. with LVN 3, LVN 3 stated that on 6/9/2026, LVN 4 reported Resident 2's allegation against CNA 4. LVN 3 stated CNA 4 allegedly went on top of Resident 2 and rough handled the resident. LVN 3 stated she did not document the assessment and monitoring in the resident's medical record following the resident's alleged abuse. LVN 3 stated she did not notify Resident 2's attending physician and family about the resident's alleged physical abuse from CNA 4. During a telephone interview on 7/1/2026 at 10:16 a.m. with LVN 4, LVN 4 stated on 6/9/2026 between 1 a.m. to 2 a.m., Resident 2 reported that CNA 4 punched her (Resident 2) on the face. LVN 4 stated she did not document her assessment and monitoring on Resident 1's medical record following the resident's alleged abuse. LVN 4 stated she waited for the DON's instructions. LVN 4 stated she sent a text message to the DON but did not receive a response from the DON. LVN 4 stated she did not notify Resident 2's attending physician and family about the resident's alleged physical abuse from CNA 4. During a concurrent interview and record review on 7/1/2026 at 1:17 p.m. with RN 1, Resident 2's medical records were reviewed. RN 1 stated there was no documented evidence of Resident 2's assessment and monitoring on 6/9/2026 to 6/30/2026 related to Resident 2's allegation of abuse against CNA 4. RN 1 stated there was no documented evidence that Resident 2's attending physician and family were notified about the resident's alleged physical abuse from CNA 4. RN 1 stated care not documented was considered not provided. RN 1 stated that failure to document Resident 1's medical status assessment and monitoring following an alleged physical abuse could result in emotional distress and put Resident 2's safety at risk. During an interview on 7/1/2026 at 3:14 p.m. with the DON, the DON stated on 6/12/2026, Resident 2 reported that CNA 4 was rough on the resident while changing the resident's disposable brief. The DON stated Resident 2 did not have a Change of Condition (COC - when there is a sudden change in a resident's condition) and the resident's reported concern was documented as a grievance. The DON stated that on 6/9/2026 LVN 4 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sent him (the DON) a text message indicating Resident 2's allegation that CNA 4 went on top of Resident 2 and punched the resident. The DON stated he read LVN 4's text message on 6/30/2026, 21 days after LVN 4 reported the alleged abuse. The DON stated Resident 2 should be monitored every shift for 72 hours after a change of condition. The DON stated Resident 2 was not assessed and monitored following an alleged physical abuse that could result in Resident 2's medical status decline, emotional distress, and put the resident's safety at risk. The DON acknowledged and stated the facility failed to ensure Resident 2 was assessed and monitored following the resident's allegation of abuse against CNA 4. During a review of the facility's policy and procedure (PnP) titled, Comprehensive Assessments, last reviewed on 5/20/2026, the PnP indicated comprehensive assessments are conducted to assist in developing person-centered care plan. During a review of the facility's PnP titled, Charting and Documentation, last reviewed on 5/20/2026, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The PnP indicated documentation in the medical record will be objective, complete and accurate. During a review of the facility's PnP titled, Change in a Resident's Condition or Status, last reviewed on 5/20/2026, the PnP indicated the nurse will notify the resident's attending physician or physician on call when there has been a (an).significant change in the resident's physical, emotional, mental condition. need to alter the resident's medical treatment significantly. The PnP indicated unless otherwise instructed by the resident, a nurse will notify the resident's representative when. there is a significant change in the resident's physical, mental, or psychosocial status. The PnP indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical or mental condition or status.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. During an interview and record review, the facility failed to ensure one of four sampled residents (Resident 1), who had a moderate risk for falls (as indicated in Resident 1's Fall Risk Observation and Assessment), was free from falls and injury by failing to ensure Resident 1 was supervised and assisted while taking a shower in the shower room. As a result, on 6/4/2026 between 9 a.m. to 10 a.m., Resident 1 fell to the ground while taking a shower in the shower room. Resident 1's fall was not reported to the licensed nurses until 6/6/2026, two days following the fall, when Resident 1 complained of right lower back and right buttock pain. Resident 1's fall resulted in a bluish discoloration with diffused yellow edges on the right iliac crest (the curved top ridge of the hip bone) and right buttock. Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted Resident 1 on 9/24/2024 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), chronic obstructive pulmonary disease (COPD - a progressive, long-term lung condition that damages the airways and air sacs, making it hard to breathe), and spondylopathy (any disease or disorder of the spine). During a review of Resident 1's Physician Order, dated 12/25/2024, the Physician Order indicated apixaban (also known as Eliquis - a prescription anticoagulant medication, taken by mouth, that acts as a blood thinner) 2.5 milligrams (mg - unit of measurement), every 12 hours for atrial fibrillation (a type of irregular heartbeat). During a review of Resident 1's Care Plan Report on Falls, last revised on 1/15/2026, the Care Plan Report indicated Resident 1 was a high risk for falls with or without injury related to antihypertensive medications (a prescribed medication that lowers a person's blood pressure [the force of person's blood pushing against the walls of arteries as heart pumps it throughout the body]), diuretic medication (used to help the body eliminate excess salt and water through urine), hypoglycemia (low blood sugar), and unsteady gait. Resident 1's Care Plan Interventions indicated to anticipate and meet the resident's needs, monitor for changes in condition affecting risk for falls, notify Resident 1's physician, and monitor the resident for delayed injury for 72 hours. During a review of Resident 1's Fall Risk Observation and Assessment, dated 3/30/2026, the Fall Risk Observation and Assessment indicated Resident 1 had a total score of 12. A fall risk score of nine to 15 indicated Resident 1 was a moderate risk for falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/30/2026, the MDS indicated Resident 1's cognitive (refers to the mental processes involved in gaining knowledge, understanding, and thinking) skills for daily decision making was intact. The MDS indicated that Resident 1 required partial and moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for shower and bathing. The MDS indicated that Resident 1 required setup assistance (resident completes activity while the helper assists prior to or following the activity) eating, oral hygiene, and toileting. During a review of Follow up Question Report, Resident 1's Bathing Task, dated 6/4/2026, the Bathing Task indicated Resident 1 was provided shower with partial or moderate assistance. During a review of Resident 1's Change in Condition (COC - when there is a sudden change in a resident's condition) Evaluation, dated 6/6/2026, the COC Evaluation indicated the resident had a fall that resulted to a blue discoloration with diffused yellow edges on the right iliac crest (the curved top ridge of the hip bone) and right buttocks. During a review of Resident 1's General Acute Care Hospital (GACH) History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings) Note, dated 6/9/2026, the H&P indicated Resident 1 complained of persistent right flank and lower lumbar pain with visible bruising following a fall. The Assessment section of the H&P indicated Resident 1 had ecchymosis (bruise) and tenderness on the right lower flank region. During an interview on 6/30/2026 at 11:50 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 6/6/2026, Resident 1 complained of right lower back pain, neck pain, and dizziness. CNA 1 stated (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 reported that he (Resident 1) had a fall on 6/4/2026 inside the shower room. CNA 1 stated she checked Resident 1's back and observed a purplish bruise on the right lower back. CNA 1 stated she immediately notified Licensed Vocational Nurse (LVN) 1. During an interview on 6/30/2026 at 11:59 a.m. with Resident 1, Resident 1 stated on 6/4/2026, CNA 2 brought him into the shower room for his regular shower. Resident 1 stated CNA 2 placed him inside the shower cubicle, turned on the shower, and then stepped out closing the shower curtain behind her. Resident 1 stated he stood up to scrub his body and when he sat back down, he slipped and the shower chair rolled back. Resident 1 stated he informed CNA 2 that he hit his back on the shower chair's armrest and landed on his buttocks. Resident 1 stated CNA 2 pulled him up by the arm and sat him down on the shower chair. Resident 1 stated there were no licensed nurses who came to assess him after the fall. Resident 1 stated that he did not request to take the shower by himself, CNA 2 just wheeled him in the shower and stepped out of the shower area. During an interview on 7/1/2026 at 11:25 a.m. with CNA 2, CNA 2 stated Resident 1 had a shower on 6/4/2026. CNA 2 stated she assisted Resident 1 into the shower room. CNA 2 stated Resident 1 preferred to shower alone. CNA 2 stepped out and closed the shower curtain but stated Resident 1's feet were visible under the shower curtain. CNA 2 stated Resident 1 was observed sitting on the floor with the shower chair behind the resident. CNA 2 stated she used her right arm, grabbed Resident 1's right arm, and pulled the resident up using a gait belt (an assistive device used to help safely transfer or assist a person). CNA 2 stated she assisted Resident 1 back up to the shower chair, assisted him in dressing up, and then transferred the resident to the wheelchair. CNA 2 stated she did not call for assistance before moving Resident 1, following the resident's fall inside the shower room. CNA 2 stated she did not notify the licensed nurses about Resident 1's fall. CNA 2 acknowledged and stated Resident 1 should be visible during shower to assist and anticipate the resident needs. During a concurrent interview and record review on 7/1/2026 at 1:17 p.m. with Registered Nurse (RN) 1, Resident 1's Progress Notes, dated 6/4/2026 to 6/9/2026, and Medication Administration Record (MAR) dated 6/1/2026 to 6/30/2026, were reviewed. RN 1 stated during resident showers, the CNA should be inside the shower cubicle for resident safety while personal space for resident independence was still provided. RN 1 stated there was no documented evidence of Resident 1's fall on 6/4/2026. RN 1 further stated there was no documented evidence Resident 1 was assessed and monitored following a fall from 6/4/2026 to 6/5/2026. RN 1 stated Resident 1's MAR indicated the resident was on an anticoagulant medication, which increased Resident 1's risk for bleeding. RN 1 stated that failure to supervise and assist Resident 1 during shower resulted in Resident 1's fall with injury. RN 1 further stated that CNA 2's failure to report Resident 1's fall could result in an undetected injury, which may cause Resident 1 adverse health outcomes and compromised safety. During an interview on 7/1/2026 at 3:14 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was a fall risk resident. The DON stated Resident 1 should be supervised and assisted during showers while respecting resident privacy. The DON stated Resident 1's fall should be reported to the licensed nurses to ensure the resident was assessed and monitored following an unwitnessed fall. The DON stated Resident 1 had an unreported and unwitnessed fall that resulted to Resident 1's bruised lower right back. The DON further stated Resident 1 was on an anticoagulant medication that could cause undetected internal bleeding following an unwitnessed fall. The DON acknowledged and stated the facility failed to supervise and assist Resident 1 during shower. The DON further stated the facility failed to report Resident 1's fall to the licensed nurses. During a review of the facility's policy and procedure (PnP) titled, Fall Prevention and Management Program, last reviewed on 5/20/2026, the PnP indicated the purpose .to develop, implement, monitor, and evaluate residents using an interdisciplinary approach. The program will use strategies that foster resident independence and increase quality of life while promoting safety for residents and staff. The program focuses on reducing incidence of resident falls and mitigating risk of falls through a resident focused team approach. The PnP defined a fall as to suddenly go down onto the ground or floor from a higher level to a lower level that is not purposeful. The PnP indicated a fall is any (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Antelope Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44567 North 15th St. West Lancaster, CA 93534	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occasion in which a person verbalizes he or she has had a fall or when a person is found on the floor. The PnP further indicated the interdisciplinary team (IDT - a collaborative group of professionals from different disciplines - such as physicians, nurses, therapists, and social workers - who work together to create and implement a single, unified care plan for a resident) will further update care plans to identify and minimize the risk for falls. During a review of the facility's PnP titled, Bath, Shower/Tub, last reviewed on 5/20/2026, the PnP indicated for the nursing staff to assist the resident when bathing as needed, encouraging independence whenever possible. The Documentation section of the PnP indicated to record any refusals, resident concerns, skin issues, or unusual observations and to report significant findings to the nurse promptly.		